Best Endodontics *of Glenview*
MICROSCOPIC ROOT CANAL THERAPY

PATIENT REGISTRATION

Date_____

Personal Information

Last Name_____ First_____ Middle_____

Home Address_____ City_____

State_____ Zip_____ Social Security No._____

Home Ph._____ Work Ph._____ Cell Ph. _____

Date of Birth _____/_____/_____ Marital Status: Married ____ Single ____ Widow ____

Employer_____ Occupation _____

Business Address_____ Bus. Ph. _____

Spouse Name _____

Employer _____

Business Address_____ Bus. Ph. _____

Dentist Name _____ Phone _____

Dentist Address _____

City _____ State _____

Guarantor Information

Name_____ Relationship _____

Home Address_____ City_____

State_____ Zip_____ Social Security No._____

Home Ph._____ Work Ph._____ Cell Ph. _____

Dental Insurance

Primary Dental Insurance_____ Employer _____

Subscriber Name_____ ID _____

Subscriber Date of Birth _____/_____/_____

Secondary Dental Insurance_____ Employer _____

Subscriber Name_____ ID _____

Subscriber Date of Birth _____/_____/_____

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PATIENT REGISTRATION

Date_____

Medical History

Are you under a Physician's care for a long term illness? Y ____ N ____

If yes please explain: _____

*Do you premedicate for dental procedures? Y ____ N ____

*Premedicating is a standing order by your attending physician to take antibiotics before ALL dental procedures due to an existing medical condition.

For Women: Are you pregnant? Y ____ N ____ Are you nursing? Y ____ N ____

Have you ever had any of the following diseases or medical conditions?

Abnormal Bleeding	Y ____ N ____	Herpes/Fever Blisters	Y ____ N ____
Alcohol/Drug Abuse	Y ____ N ____	High Blood Pressure	Y ____ N ____
Anemia	Y ____ N ____	HIV+/AIDS	Y ____ N ____
Arthritis	Y ____ N ____	Hospitalized for any reason	Y ____ N ____
Asthma	Y ____ N ____	Kidney Problems	Y ____ N ____
Cancer/Chemotherapy	Y ____ N ____	Liver Disease	Y ____ N ____
Congenital Heart Defect	Y ____ N ____	Low Blood Pressure	Y ____ N ____
Diabetes	Y ____ N ____	Mitral Valve Prolapse	Y ____ N ____
Difficulty Breathing	Y ____ N ____	Nervous/Anxiety	Y ____ N ____
Emphysema	Y ____ N ____	Pacemaker	Y ____ N ____
Epilepsy	Y ____ N ____	Psychiatric Problems	Y ____ N ____
Heart Attack	Y ____ N ____	Radiation Treatment	Y ____ N ____
Heart Murmur	Y ____ N ____	Seizures	Y ____ N ____
Heart Surgery	Y ____ N ____	Sinus Problems	Y ____ N ____
Hemophilia	Y ____ N ____	Stroke	Y ____ N ____
Hepatitis	Y ____ N ____	Tuberculosis	Y ____ N ____
Heart Valve or Joint Replacement			Y ____ N ____

Please list any additional serious medical conditions_____

Are you allergic to any of the following?

Aspirin	Y ____ N ____	Latex	Y ____ N ____
Codeine	Y ____ N ____	Penicillin	Y ____ N ____
Epinephrine	Y ____ N ____	Sulfa	Y ____ N ____
Erythromycin	Y ____ N ____	Ibuprofen	Y ____ N ____

Please list any additional medicine allergies _____

Are you currently taking or have you ever taken any of the following medications:

Zoledronate (Zometa)	Y ____ N ____	Pamidronate (Aredia)	Y ____ N ____
Clodronate (Bonefos)	Y ____ N ____	Ibandronate (Boniva)	Y ____ N ____
Risedronate (Actonel)	Y ____ N ____	Alendronate (Fosamax)	Y ____ N ____
Tiludronate (Skelid)	Y ____ N ____	Etidronate (Didronel)	Y ____ N ____
Neridronate	Y ____ N ____	Olpadronate	Y ____ N ____
Reclast	Y ____ N ____	Alclasta	Y ____ N ____

Please list any additional medication you are taking _____

Signed_____